Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1 DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-2221-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the preauthorization letter, EOBs, claims, and documentation. The services were provided and the claims were denied per EOB based on the findings of the review organization. The services provided were preauthorized therefore they were deemed medically necessary. The claims came back denied based on extent of injury. The treatment that was provided is part of her compensable injury to her low back that she sustained on 04/20/06. In summary, it is our position that Gallagher Bassett has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered…"

Amount in Dispute: $4,155.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not include a position summary with their response.

Response Submitted by: Gallagher Bassett, 6504 Intl Pkwy, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2010	90801	$1,148.15	$233.32
August 16, 2010	96101	$507.84	$0.00
November 1, 2010	97799-CP-CA x 4.5 hours	$562.50	$0.00
November 22, 2010	97799-CP-CA x 5.5 hours	$687.50	$0.00
December 13, 2010	97799-CP-CA x 5 hours	$625.00	$0.00
December 14, 2010	97799-CP-CA x 5 hours	$625.00	$0.00
TOTAL		$4,155.99	$233.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
3. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
4. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
5. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
6. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 5, 2010
   - W12 – EXTENT OF INJURY

   Explanation of benefits dated October 26, 2010
   - 216 – BASED ON PEER REVIEW EXTENT OF INJURY
   - 219 – Based on extent of injury.

   Explanation of benefits dated November 6, 2010
   - 219 – Based on extent of injury.

   Explanation of benefits dated November 16, 2010
   - 219 – Based on extent of injury.

   Explanation of benefits dated December 20, 2010
   - W12 – EXTENT OF INJURY
   - 216 – BASED ON PEER REVIEW
   - 216 – Based on the findings of the review organization.

   Explanation of benefits dated December 28, 2010
   - 216 – Based on the findings of the review organization.

   Explanation of benefits dated December 30, 2010
   - 219 – Based on extent of injury.

   Explanation of benefits dated January 12, 2011
   - 219 – Based on extent of injury.

   Explanation of benefits dated January 22, 2011
   - 219 – Based on extent of injury.

   Explanation of benefits dated February 12, 2011
   - 219 – Based on extent of injury.

Issues

1. Has the extent of injury issue been resolved?
2. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. A benefit review conference was held on April 4, 2007 to mediate resolution of the disputed issue, however the parties were unable to reach an agreement. A Contested Case Hearing was held on May 16, 2007 to decide if the compensable injury of April 20, 2006 includes adjustment disorder, anxiety, and depression. It was determined by the Division, that the injured employee's compensable injury of April 20, 2006 does include the

lumbar sprain/strain, adjustment disorder, anxiety, and depression. The ICD-9 code billed on the CMS 1500 forms is 847.2 (lumbar sprain/strain). The Decision of the hearing officer is final. The Division has determined that the extent of injury issue has been resolved.

2. The respondent denied the disputed services based on "216 – Based on the findings of the review organization." According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date for the services rendered on November 1, 2010 through November 14, 2010. The Division finds that the respondent's denial reason of "216" has been supported.

   Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code §134.600(p)(7) requires preauthorization of "all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program." Review of the submitted preauthorization letter dated June 15, 2010 supports CPT code 90801 rendered on July 13, 2010 was preauthorized, however CPT code 96101 rendered on August 16, 2010 was denied preauthorization approval. 28 Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." On April 11, 2012, the Division requested a copy of the preauthorization letter regarding disputed dates of service, November 1, 2010, November 22, 2010, December 13, 2010 and December 14, 2010 from the requestor. On April 11, 2012, the Division received the requested preauthorization from the requestor. Review of the submitted preauthorization letter dated September 28, 2010 supports the Chronic Pain Management program was approved for 5 x week x 2 weeks (10 visits) under authorization number 9008080 with a start date of September 23, 2010 and an end date of October 29, 2010. The disputed dates of service of November 1, 2010 through December 14, 2010 are outside of the authorized time frame. Review of the submitted documentation finds that the Requestor did not submit documentation to sufficiently support preauthorization approval was obtained prior to providing the chronic pain management services, CPT code 97799-CP-CA, in dispute in accordance with 28 TAC §134.600. Therefore, the respondent's denial reason of "216" is supported.

   CPT Code 90801 for DOS July 13, 2010: The 2010 Division conversion factor to be applied is $54.32. $54.32 WC CF/36.8729 Medicare CF x $$158.38 Participating amount = $233.32.

3. The requestor has failed to support that the remaining services in dispute are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute, except for CPT Code 90801 regarding disputed date of service July 13, 2010. As a result, $233.32 is ordered for CPT Code 90801 regarding disputed date of service July 13, 2010 only.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $233.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 25, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.